



## **Texas Department of Insurance**

### **Division of Workers' Compensation**

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

512-804-4000 telephone • 512-804-4811 fax • [www.tdi.texas.gov](http://www.tdi.texas.gov)

## **MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION**

### **GENERAL INFORMATION**

#### **Requestor Name and Address**

TEXOMA MEDICAL CENTER  
3255 W PIONEER PKWY  
ARLINGTON TX 76013

#### **Respondent Name**

Texas Mutual Insurance Co

#### **Carrier's Austin Representative Box**

Box Number 54

#### **MFDR Tracking Number**

M4-12-1590-01

#### **MFDR Date Received**

January 12, 2012

### **REQUESTOR'S POSITION SUMMARY**

**Requestor's Position Summary:** "We have found in this audit you have not paid what we determine as a mount for these outpatient services."

**Amount in Dispute:** \$1,076.70

### **RESPONDENT'S POSITION SUMMARY**

**Respondent's Position Summary:** "This dispute concerns the requestor's assertion it is due additional payment for outlier service provided 10/3/11. Texas Mutual does not agree."

**Response Submitted by:** Texas Mutual Insurance Co

### **SUMMARY OF FINDINGS**

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
October 3, 2011	Outpatient Hospital Services	\$1,076.70	\$0.00

### **FINDINGS AND DECISION**

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

#### **Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403, titled *Hospital Facility Fee Guideline – Outpatient*, sets out the reimbursement guidelines for facility services provided in an outpatient acute care hospital.
3. 28 Texas Administrative Code §134.203, titled *Medical Fee Guideline for Professional Services*, sets out the reimbursement guidelines for professional medical services.
4. 28 Texas Administrative Code §134.402 titled *Ambulatory Surgical Center Guidelines*, sets out the reimbursement guidelines for facility services.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:  
Explanation of benefits dated November 15, 2011

- CAC-B15 – THIS SERVICE/PROCEDURE REQUIRES THAT A QUALIFYING SERVICE/PROCEDURE BE RECEIVED AND COVERED. THE QUALIFYING OTHER SERVICE/PROCEDURE HAS NOT BEEN RECEIVED/ADJUDICATED.
- CAC-B5 – COVERAGE/PROGRAM GUIDELINES WERE NOT MET OR WERE EXCEEDED.
- CAC-W1 – WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT
- CAC-131 – CLAIM SPECIFIC NEGOTIATED DISCOUNT.
- CAC-193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.
- CAC-97 – THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED.
- 356 – THIS OUTPATIENT ALLOWANCE WAS BASED ON THE MEDICARE'S METHODOLOGY (PART B) PLUS
- 370 – THIS OUTPATIENT ALLOWANCE WAS CALCULATED ACCORDING TO THE APC RATE PLUS A MARKUP.
- 446- THIS ADD-ON CODE HAS BEEN DENIED AS THE PRINCIPAL PROCEDURE WAS NOT BILLED.
- 618 – THE VALUE OF THIS PROCEDURE IS PACKAGED INTO THE PAYMENT OF OTHER SERVICES PERFORMED ON THE SAME DATE OF SERVICE.
- 629 – THE MEDICALLY UNLIKE EDITS (MUE) FROM CMS HAS BEEN APPLIED TO THIS PROCEDURE CODE.
- 724 – NO ADDITIONAL PAYMENT AFTER A RECONSIDERATION OF SERVICES.
- 728 – THIS BILL WAS REVIEWED/DENIED IN ACCORDANCE WITH YOUR FIRST HEALTH CONTRACT.
- 729 – THIS BILL WAS REVIEWED IN ACCORDANCE WITH YOUR FIRST HEALTH CONTRACT.

#### Explanation of Benefits Dated December 15, 2011

- CAC-B15 – THIS SERVICE/PROCEDURE REQUIRES THAT A QUALIFYING SERVICE/PROCEDURE BE RECEIVED AND COVERED. THE QUALIFYING OTHER SERVICE/PROCEDURE HAS NOT BEEN RECEIVED/ADJUDICATED.
- CAC-B5 – COVERAGE/PROGRAM GUIDELINES WERE NOT MET OR WERE EXCEEDED.
- CAC-W1 – WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT
- CAC-131 – CLAIM SPECIFIC NEGOTIATED DISCOUNT.
- CAC-193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.
- CAC-97 – THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED.
- 356 – THIS OUTPATIENT ALLOWANCE WAS BASED ON THE MEDICARE'S METHODOLOGY (PART B) PLUS
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- 446- THIS ADD-ON CODE HAS BEEN DENIED AS THE PRINCIPAL PROCEDURE WAS NOT BILLED.
- 618 – THE VALUE OF THIS PROCEDURE IS PACKAGED INTO THE PAYMENT OF OTHER SERVICES PERFORMED ON THE SAME DATE OF SERVICE.
- 629 – THE MEDICALLY UNLIKE EDITS (MUE) FROM CMS HAS BEEN APPLIED TO THIS PROCEDURE CODE.
- 724 – NO ADDITIONAL PAYMENT AFTER A RECONSIDERATION OF SERVICES.
- 728 – THIS BILL WAS REVIEWED/DENIED IN ACCORDANCE WITH YOUR FIRST HEALTH CONTRACT.
- 729 – THIS BILL WAS REVIEWED IN ACCORDANCE WITH YOUR FIRST HEALTH CONTRACT.

#### **Issues**

1. Are the disputed services subject to a contractual agreement between the parties to this dispute?
2. What is the applicable rule for determining reimbursement for the disputed services?
3. What is the recommended payment amount for the services in dispute?
4. Is the requestor entitled to reimbursement?

#### **Findings**

1. According to the explanation of benefits dated November 15, 2011, the carrier reduced the medical bill using codes 728 - "THIS BILL WAS REVIEWED/DENIED IN ACCORDANCE WITH YOUR FIRST HEALTH CONTRACT." and 729 – "THIS BILL WAS REVIEWED IN ACCORDANCE WITH YOUR FIRST HEALTH

CONTRACT.” No documentation was found to support that a contract exists between the parties, nor can the division establish what type of contract - Informal or Voluntary pursuant to Texas Labor Code §413.011 (d-1) through (d-3), or Health care Certified Network Texas Insurance Code §1305 - was allegedly accessed. The division further notes that Texas Labor Code §413.011 (d-1) through (d-3) regarding informal and voluntary networks for the type of service in this dispute expired on December 31, 2010. The division concludes that reduction codes 728 and 729 are not supported, for that reason; the services in dispute will be reviewed pursuant to the applicable division fee guidelines.

2. This dispute relates to facility services performed in an outpatient hospital setting with reimbursement subject to the provisions of 28 Texas Administrative Code §134.403, which requires that the reimbursement calculation used for establishing the maximum allowable reimbursement (MAR) shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register with the application of minimal modifications as set forth in the rule. Per §134.403(f)(1), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 200 percent, unless a facility or surgical implant provider requests separate reimbursement of implantables. Review of the submitted documentation finds that separate reimbursement for implantables is not applicable.
3. Under the Medicare Outpatient Prospective Payment System (OPPS), each billed service is assigned an Ambulatory Payment Classification (APC) based on the procedure code used, the supporting documentation and the other services that appear on the bill. A payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC per encounter. Payment for ancillary and supportive items and services, including services that are billed without procedure codes, is packaged into payment for the primary service. A full list of APCs is published quarterly in the OPPS final rules which are publicly available through the Centers for Medicare and Medicaid Services (CMS) website. Reimbursement for the disputed services is calculated as follows:
  - Procedure code J2060 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
  - Procedure code J7030 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
  - Procedure code J7042 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
  - Procedure code J7042, date of service October 4, 2011, has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
  - 28 Texas Administrative Code §134.402(d) states, in pertinent part, “for coding, billing, reporting, of facility services covered in this rule, Texas workers’ compensation system participants shall apply the Medicare payment policies in effect on the date a service is provided...” Per Medicare policy, procedure code 96351 is an add-on procedure code and must be submitted with an appropriate primary procedure code. Separate payment is not recommended.
  - 28 Texas Administrative Code §134.402(d) states, in pertinent part, “for coding, billing, reporting, of facility services covered in this rule, Texas workers’ compensation system participants shall apply the Medicare payment policies in effect on the date a service is provided...” Per Medicare policy, procedure code 96351, date of service October 4, 2011, is an add-on procedure code and must be submitted with an appropriate primary procedure code. Separate payment is not recommended.
  - Procedure code 36415 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is \$3.00. 125% of this amount is \$3.75
  - Procedure code 80053 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is \$14.87. This amount multiplied by 2 units is \$29.74. 125% of this amount is \$37.18
  - Procedure code 82375 has a status indicator of A, which denotes services paid under a fee schedule or

payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is \$17.35. 125% of this amount is \$21.69

- Procedure code 82550 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is \$9.17. 125% of this amount is \$11.46
- Procedure code 82553 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is \$8.66. 125% of this amount is \$10.83
- Procedure code 82553 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is \$8.66. 125% of this amount is \$10.83
- Procedure code 82805 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is \$39.94. This amount multiplied by 2 units is \$79.88. 125% of this amount is \$99.85
- Procedure code 83050 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is \$4.14. 125% of this amount is \$5.18
- Procedure code 83605 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is \$15.03. This amount multiplied by 2 units is \$30.06. 125% of this amount is \$37.58
- Procedure code 83874 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is \$18.17. 125% of this amount is \$22.71
- Procedure code 83880 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for

Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is \$47.77. 125% of this amount is \$59.71

- Procedure code 84484 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is \$13.85. 125% of this amount is \$17.31
- Procedure code 84484 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is \$13.85. 125% of this amount is \$17.31
- Procedure code G0434 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Payment for this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(d)(1). The fee listed for this code in the Medicare DMEPOS fee schedule is \$15.64. 125% of this amount is \$19.55
- Procedure code 85027 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is \$9.11. This amount multiplied by 2 units is \$18.22. 125% of this amount is \$22.78
- Procedure code 81003 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is \$3.16. 125% of this amount is \$3.95
- Procedure code 71010 has a status indicator of Q3, which denotes conditionally packaged codes that may be paid through a composite APC. If OPPS criteria are met, this service is assigned to composite APC 8003. This service meets the criteria for composite payment. A service that is assigned to a composite APC is a major component of a single episode of care. The hospital receives one payment through a composite APC for multiple major separately identifiable services. Payment for any combination of designated procedures performed on the same date is packaged into a single payment. If a claim includes a composite payment that pays for more than one otherwise separately paid service, the charges for all services included in the composite are summed up to one line. To determine outlier payments, a single cost for the composite APC is estimated from the summarized charges. Total packaged cost is allocated to the composite line-item in proportion to other separately paid services on the claim. The payment for composite services is calculated below.
- Procedure code 99285 has a status indicator of Q3, which denotes conditionally packaged codes that may be paid through a composite APC. If OPPS criteria are met, this service is assigned to composite APC 8003. This service meets the criteria for composite payment. A service that is assigned to a composite APC is a major component of a single episode of care. The hospital receives one payment through a composite APC for multiple major separately identifiable services. Payment for any combination of designated procedures performed on the same date is packaged into a single payment. If a claim includes a composite payment that pays for more than one otherwise separately paid service, the charges for all services included in the composite are summed up to one line. To determine outlier payments, a single cost for the composite APC is estimated from the summarized charges. Total packaged cost is allocated to the composite line-item in proportion to other separately paid services on the claim. The payment for composite services is calculated below.
- Per the Centers for Medicare Services, (CMS), National Corrective Coding Initiatives (CCI) edits, procedure code 96374 and 99285 should not be reported together when performed on the same date unless an

appropriate modifier is appended to the component code to differentiate between the services provided. This procedure is a component service of procedure code 99285 performed on the same date. Separate payment for the services billed may be justified if a modifier is used appropriately and supported by documentation. The requestor billed the disputed service without a modifier; therefore, separate payment is not recommended.

- Procedure code 93005 has a status indicator of S, which denotes a significant procedure, not subject to multiple-procedure discounting, paid under OPPS with separate APC payment. These services are classified under APC 0099, which, per OPPS Addendum A, has a payment rate of \$27.26. This amount multiplied by 60% yields an unadjusted labor-related amount of \$16.36. This amount multiplied by the annual wage index for this facility of 0.9506 yields an adjusted labor-related amount of \$15.55. The non-labor related portion is 40% of the APC rate or \$10.90. The sum of the labor and non-labor related amounts is \$26.45 multiplied by 3 units is \$79.35. The cost of these services does not exceed the annual fixed-dollar threshold of \$2,025. The outlier payment amount is \$0. The total Medicare facility specific reimbursement amount for this line is \$79.35. This amount multiplied by 200% yields a MAR of \$158.70.
  - Procedure code G0378 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
  - Procedure code G0378, date of service October 4, 2011, has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
  - Procedure codes 71010 and 99285 have a status indicator of Q3, which denotes conditionally packaged codes that may be paid through a composite APC. A service that is assigned to a composite APC is a major component of a single episode of care. The hospital receives one payment through a composite APC for multiple major separately identifiable services. Payment for any combination of designated procedures performed on the same date is packaged into a single payment. These services are assigned to composite APC 8003, for level II extended assessment and management services. If a claim includes a composite payment that pays for more than one otherwise separately paid service, the charges for all services included in the composite are summed up to one line. To determine outlier payments, a single cost for the composite APC is estimated from the summarized charges. Total packaged cost is allocated to the composite line-item in proportion to other separately paid services on the claim. This line is assigned status indicator V, which denotes a clinic or emergency department visit paid under OPPS with separate APC payment. These services are classified under APC 8003, which, per OPPS Addendum A, has a payment rate of \$714.33. This amount multiplied by 60% yields an unadjusted labor-related amount of \$428.60. This amount multiplied by the annual wage index for this facility of 0.9506 yields an adjusted labor-related amount of \$407.43. The non-labor related portion is 40% of the APC rate or \$285.73. The sum of the labor and non-labor related amounts is \$693.16. The cost of these services does not exceed the annual fixed-dollar threshold of \$2,025. The outlier payment amount is \$0. The total Medicare facility specific reimbursement amount for this line is \$693.16. This amount multiplied by 200% yields a MAR of \$1,386.32.
4. The total allowable reimbursement for the services in dispute is \$1,946.69. This amount less the amount previously paid by the insurance carrier of \$2,139.68 leaves an amount due to the requestor of \$0.00. No additional reimbursement can be recommended.

### **Conclusion**

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is \$0.00.

### ***ORDER***

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

### **Authorized Signature**

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Signature	Medical Fee Dispute Resolution Officer	May , 2013 Date

### ***YOUR RIGHT TO APPEAL***

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.**

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**